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South Dakota Consortium

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Nursing Facilities, Swingbeds, Assisted Living, Hospice

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Updated February 2000

Introduction

This paper will address the health care options available to the citizens of South Dakota, specifically in Nursing Facilities (long-term care/nursing homes), swing beds, assisted living centers and hospice. The intent of this white paper is to review the role of the registered nurse and licensed practical nurse in the provision of care in each type of facility. Trends for the future will be addressed as well as the impact these trends will have on the nursing profession in terms of education, service and regulations. The objective of this white paper is to identify what nursing in South Dakota can do to best meet the needs of the consumers of health care in nursing facilities, swingbeds, assisted living centers and hospices.

Definitions

The South Dakota Department of Health¹ and the South Dakota Department of Social Services² provided the following definitions to help clarify the difference in types of services. The terms “Long Term Care” or “Nursing Homes” are being replaced with the term “Nursing Facility”, but in this report they are used interchangeably especially when reference is made to historical data.

- ♦ **Licensed Nursing Center (Nursing Facility)** is the new politically correct term for facilities that were previously referred to as nursing homes or long-term care facilities. The federal regulations have changed the term to Nursing Facility. It is a facility licensed as a nursing home by the Department of Health and maintained and operated for the express or implied purpose of providing care to one or more persons, whether for consideration or not, who are not acutely ill but require nursing care and related medical services of such complexity as to require professional nursing care under the direction of a physician 24 hours a day.
- ♦ **Swingbed** is a licensed hospital bed, which has been approved by the Department of Health to also provide short-term nursing facility care pending the availability of a nursing facility bed.
- ♦ **Assisted living centers** are facilities that may not admit or retain residents who require on-going nursing care. An assisted living center which admits or retains

residents who require administration of medications must employ or contract with a licensed nurse who reviews resident care and conditions at least weekly with unlicensed assistive personnel. Assisted living centers can admit residents with cognitive impairments that prevent them from understanding, making themselves understood, or communicate their needs as determined by their physician of record. Assisted living centers may admit or retain residents with physical impairments that prevent them from walking independently if a call system is in place. Assisted living centers may admit and retain residents who are not capable of self-preservation if there is an automatic sprinkler system. Assisted living centers may admit or retain residents who are dependent on supplemental oxygen if staff is trained in oxygen safety and practice safe oxygen handling procedures. Assisted living centers may admit or retain residents requiring special diets if they contract with a dietitian who approves written menus and diet extensions, assesses residents' special diet needs, plans individual diets, and provides guidance to dietary staff in areas of preparation, service and monitoring residents' acceptance of these diets.

- ◆ **Hospice** is a coordinated interdisciplinary program of home and inpatient care. Hospice provides or coordinates palliative and supportive care to meet the needs of a terminally ill patient and the patient's family arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness and dying and includes formal bereavement programs as an essential component.

History/Trends

In 1953, there were 100 facilities classified as nursing homes. Two classifications of facilities remained until 1965, at which time four categories were instituted. Then in 1974, three classifications were established; skilled nursing, intermediate nursing and supervised personal care. In 1991, the term "Supervised Personal Care Facility" was changed to "Assisted Living Center". In 1995, the distinction between skilled and intermediate was eliminated. In December of 1998, there were 115 facilities; with 90 being Medicare-certified skilled nursing facilities. The Human Services Center in Yankton has 119 beds as well. Occupancy rate has fallen from 95% in the early 1990s to less than 90% by June of 1999.³ The nursing facilities are serving a much older and sicker population than they did in the early 1990s. The average length of stay in a nursing facility declined from 656 days in 1990 to 420 days in 1998. This trend of decreased stay is in part due to the care provided for subacute and rehabilitative conditions. Medicaid is the primary payment resource for the majority of nursing facility care covering approximately sixty percent (60%), Medicare covers six percent (6%), and Private Pay sources the remaining thirty-four percent (34%).⁴

In 1986 a Task Force on Long Term Care was established to identify the most critical problems in the long-term care delivery system. The goal of that Task Force was to establish a plan for long-term care services, which would address the actual needs of the elderly and promote their health, independence and functional ability. During 1986-1988,

there were significant changes in the delivery of long-term care services in South Dakota. One change was the implementation of a moratorium on long-term care beds. This was initially a three-year moratorium with extensions granted since 1988. The moratorium was also extended to the year 2005 by the 2000 legislature. However, the legislature has pledged to seek ways to build nursing homes on the Pine Ridge Indian Reservation and other reservations.⁵ As a result of the Task Force, South Dakota was able to develop a more effective system of long-term care that offers a full range of services, both in-home and community-based, as well as institutional care.

In the past 10 years the development and use of swing beds has increased by 69 licensed beds. Although the number of beds, from 362 to 431, and admissions, from 2,245 to 4,496, has steadily increased, the number of days of care has been declining since 1991. By 1998, there were 44 hospitals that had swingbeds with a length of stay of approximately 9.7 days compared to a length of stay of 22.5 days in 1988 and 12.7 in 1996. Swingbeds account for less than two percent of long-term care resident days.⁴

The proportion of non-nursing facility beds such as elder care complexes that include assisted living and independent living beds had increased dramatically by 1999.³ There has also been a significant increase in the number of Assisted Living Centers in South Dakota. In 1995, there were approximately 65 Assisted Living Centers with 1,200 beds that had an occupancy rate of 71.1%. By 1999, this number has increased to 116 centers with a total of 2,197 beds and an occupancy rate of approximately 75%. Assisted living residents are generally individuals who need some assistance with activities of daily living but do not require the 24-hour skilled medical care provided in nursing facilities. Assisted living is a popular choice as it often offers the right blend of services and care at a reasonable cost. For some, it bridges the gap between living independently and living in a nursing facility. While some community markets may already be saturated, the concept is expected to continue growing and to have a major impact on future services and related public policy including financing issues. Approximately seventy-four (74%) of the residents and families privately pay for assisted living care. Assisted living days are eleven percent (11%) of the total long-term care resident days.⁴

There are 14 Hospice programs with 18 additional branches that are Medicare certified and one free standing that is not Medicare certified. Payment remains on a per diem basis but an increase in the payment rate of 0.5% in fiscal year 2001 and 0.7% in 2002 is anticipated. Hospice programs are still highly scrutinized for potential fraud and abuse and patients admitted for non-cancer diagnosis receive additional review. The non-cancer diagnosis is sometimes deemed chronic instead of terminal and thus physicians are reluctant to admit them to the hospice until late in the stages of care. The late referrals into a hospice increase the cost per case as they enter when the need for care is extremely high.⁶

Role of Licensed Practical Nurse (LPN)

In recent years, LPNs have practiced in a changing environment and have experienced expanding roles in the health care system. The LPN's scope of practice include: the performance of any acts in the care, treatment, or observation of the ill, injured or infirmed; maintenance of health of others and promotion of health care; assisting with health

counseling and teaching; applying procedures to safeguard life and health, including the administration of medications and treatments consistent with the practical nurse's education and preparation under the direction of a physician, dentist or registered nurse.

The LPN is an accountable member of the health-care team promoting and maintaining health, preventing disease and disability, caring for and rehabilitating individuals who are experiencing an altered health state, and contributing to the ultimate quality of life until death. LPNs know and utilize the nursing process in planning, implementing, and evaluating health services and nursing care for the individual patient or group. LPN functions include the performance for compensation of authorized acts of nursing which utilize specialized knowledge and skills and which meet the health needs of people in a variety of settings under the direction of qualified health professions. The LPNs can practice in a variety of settings and have a role in nursing facilities, swingbeds, assisted living centers and hospice as a direct provider of patient/resident care.

Role of Registered Nurse (RN)

The scope of practice of the RN includes nursing diagnosis of human responses to actual or potential health problems of individuals or groups providing preventative, restorative and supportive care, health teaching and counseling, case finding and referral; and administration, supervision, delegation, evaluation and teaching of health and nursing practice; which require substantial specialized knowledge, judgment and skill based upon the principles of the biological, physiological, behavioral and sociological sciences, and for which the RN bears responsibility and accountability.

In nursing facilities, the registered nurses' role includes such positions as Director of Nurses, Charge Nurse, Minimum Data Set Coordinator, Director of Discharge Planning, Inservice Education Coordinator and nurse assistant training facilitator, as well as provider of resident care.

In swingbed units, the role of the registered nurse typically is that of a patient care supervisor, coordinator of services and delegator of duties regarding direct patient care. Discharge planning and coordinating of services both in the unit and after discharge are a high priority in these nursing positions.

In assisted living facilities, even though on-going nursing care is not permitted, registered nurses enter as home-health nurses, employees or contractors to supervise medication administration and provide the staff with inservices. Many managers of these facilities are registered nurses.

In hospice, the registered nurse provides direct patient care and is the supervisor and coordinator of other patient and family-related services. The RN needs to have expertise in the areas of pain management, patient rights, ethical issues and possess the ability to deal with death and dying issues as well as coordinate support services for the patient and family.

Role of the Advanced Practice Nurse (APN)

The concepts of risk assessment, prevention of complications of chronic illness, and supported-decisioning for older adults and their families are the general themes for the effective advanced practice nurse in any of these settings. Appropriate application of

meaning to target data and effective communication and information handling are also integral to the effective APN role. The APN can provide objective determination of function in patients such as person-environment fit and best placement/level of care required.

In all of these environments of care, the APN could facilitate primary care in collaboration with physicians or physician groups, serve as a consultant/educator for staff education regarding such topics as normal aging, cognitive impairment, recognizing delirium, illness presentation and report abnormal findings. They can be a consultant on issues such as quality of life, individualization of plans of care, or on specific patient issues such as identification and treatment for depression, wound management, incontinence and bladder training as well as polypharmacy concerns. The APN is also prepared to be a program consultant, conduct research on subjects related to clinical and socio-economic issues, provide staff/public education and address public policy.

The APN could fulfil the role of an outcome manager to evaluate effective clinical nursing strategies that promote self-care, functional independence, wellness and reduced lengths of stay. The end result would be lower costs in the utilization of services to and reduce recidivism to costly care settings.

Current Reality

The internal factors and trends that appear to have affected the provision of care in these four types of nursing settings include the maintenance of a high percent of occupancy even though the average length of stay per resident is declining in nursing facilities. More hospitals are providing swingbed services, but the length of stay in swingbeds is also declining. The assisted living facilities are the fastest growing segment in this market with new facilities being opened almost monthly. The competition may become intense for residents in these facilities. Hospice, although an age-old concept in health care, has just in recent years developed in South Dakota and continues to grow in services and locations for South Dakota consumers.

The trends indicate that a greater number of registered nurses are being employed in nursing facilities as a result of the classification system and because of a higher acuity of the resident being admitted. The services of Advanced Practice Nurses still need to be better utilized in the future. The Medicare Certified Nursing Facilities provide more rehabilitation and subacute care services.

The external factors that have contributed to the changes in these settings included the shortened lengths of stay in hospitals, the development of swingbeds and hospice, and a change in the use of nursing facilities with more rehabilitation care. Ultimately, more health care is being provided outside hospital walls. The external factors affecting the lengths of stay in hospitals, swingbeds, and nursing facilities have initiated an increase in the use and development of creative alternative services. The utilization of hospice and assisted living services has increased dramatically as a result of these changes and the increase in use of out-of-facility care.

Conglomerates are purchasing community facilities and they may lose touch with the local community and their specific needs. Many facilities are moving from non-profit status to for-profit status, which may have an impact on the quality of care.

The internal factors, external factors, lengths of stay, and development of additional services are a direct result of payment sources which have been a driving force in the development of alternative services. Payment sources that are instrumental in paying for the services include long-term care insurance, Medicare/Medicaid, HMOs, private pay, and, of course, state pay resources.

Predictions for the Future

A review of the history of long-term service along with the changes due to the implementation of DRGs (diagnosis related groups) and payment sources have ultimately shortened lengths of stay in hospitals as well as nursing facilities. The public expects quicker recovery and is dissatisfied with a long recuperation period. Some persons who will need nursing facility, swingbed, or assisted living will not have access to those services or the financial resources to obtain them, so community alternatives will be needed. Training will be needed for the providers of care in non-institutional settings and family/support persons. Each community will need to decide on what level of care that community can afford and accept. Nurses will need social skills to lead in rural areas through delegation, referral, collaboration and effective practice patterns.

There has been a reduction in funding for long-term care and as a result many nursing facilities may be forced to close. The nursing facility in Hot Springs was threatened with closure in December of 1999 with several of the residents being relocated to other facilities before, at the last moment, a new owner was obtained and the facility remained open. The impact on the entire community is tremendous whenever access to healthcare becomes limited.

Implications for Nursing Practice

In all settings, the appropriate use of delegation, recognition of polypharmacy issues, effective leadership and management skills, and knowledge of community resources for discharge planning are deemed to be essential nursing skills. The nurse must possess an understanding of resident rights, quality of life concerns, ethical issues, and have an increased awareness of the potential for elder abuse and exploitation. Enhanced assessment skills, validated through competency testing, is critical to effective care. Since long-term care finances are very limited, the nurse will need to understand reimbursement by the payers. The general economics of care is a critical component in the nursing skill set.

The encouragement for nurses including licensed practical nurses (LPN) to complete a certification in geriatrics is being promoted. The need for nursing generalists will continue, especially in the rural areas, but the need exists for nursing specialists in the field of geriatrics. Nurses will need to partner with families in care-giving, providing the link and acting as a translator and advocate between the physician and family.

The implications for nursing practice included having knowledge of and access to community resources and durable medical equipment. Principles and application of pain management and the ability to deal with ethical issues related to death and dying are critical issues for the nurse, especially in the hospice setting. The responsibility of supervision of unlicensed assistive personnel and the delegation of medication administration remains a primary concern. Nurses need to become more politically astute and involved as the regulations from state and federal governments do dictate and impact the practice of nursing in nursing facilities.

Implications for Nursing Education

The students need to be taught concepts in pain management, specific geriatric issues and techniques on how to identify and access community resources. Students must be taught about resident/patient rights, quality of life, ethical decision issues, as well as an understanding of the regulations that affect nursing facilities, assisted living facilities, swing beds and hospice. Curriculums need to include outcome-based nursing, assessment and identification of risk factors and the utilization of assessment tools or instruments such as the MDS 2.0. Leadership and delegation responsibilities must be included in every level of education as nurses from each type of school are placed in positions requiring these skills. Nurses or providers without baccalaureate degrees should not be discounted but rather individual strengths should be recognized.

These areas need not only be addressed in the educational facilities; but must be taught to nurses currently working in these health care settings. The task of getting this information and enhancing the skills of nurses is going to require inservice programs, cross training and perhaps the implementation of certification recommendations.

Implications for Nursing Regulation

The scope of practice needs to be maintained to ensure that nurses provide nursing care. The Department of Health protocols may need to be reviewed to ensure that effective, safe nursing care is consistent with the scope of practice outlined by the South Dakota Board of Nursing. In the future, regulations regarding cross-jurisdictional regulations will impact nursing care in all areas. Nurses will need to be politically active to protect the consumer and the role of the nurse in providing citizens with the best possible care.

South Dakota was a test site for measuring quality in nursing facilities. South Dakota health officials used 30 clinical indicators to measure resident progress and facility care practices. This data provided an on-going means of reviewing clinical performance and giving facilities a much higher level of accountability.⁷

An LPN Task Force reviewed the scope of practice for LPNs and has proposed to expand the basic role to include IV therapy, including IV gravity drip infusions, administering pre-mixed vitamins, antibiotics, corticosteroids and H2 antagonists via IV piggyback route, routine heparin/saline flushes, routine centrally accessed line dressing changes and perform peripheral venipuncture. These changes will impact the role of the LPN in nursing facilities once implemented.

A Delegation Task Force is reviewing regulations related to the delegation of nursing tasks to unlicensed personnel. The outcome of the review may impact all facilities identified in this white paper.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has implemented the use of outcomes into its accreditation process as a means of improving the quality of care. The intent is to increase facility accountability and to drive quality improvement activities from within the facility. Nursing facilities will choose one measurement and two clinical performance indicators to track. In the future, the data obtained from this tracking may become public knowledge.⁸

The proliferation of Assisted Living is a regulatory issue and currently there are no regulations to govern how they operate. Nursing accountability and responsibility is very high in these facilities. There may need to be a moratorium on Assisted Living if the growth continues along with the implementation of stricter regulations to ensure quality of care.

Implications for Nursing Workforce

All of the implications outlined have indicated an increase in opportunities for nursing positions in a variety of health care settings. The nursing workforce will need to improve their knowledge regarding pain management, assessment skills, patient/resident rights, be informed on regulatory and reimbursement issues, and be well versed in community resources. Support for the required competency testiness and for national certification will be needed to help ensure a high quality of nursing care. The utilization of Advance Practice Nurses in the provision of care and services to consumers in nursing facilities, swingbeds, assisted living facilities and in hospice settings will promote an improved level of care. Regardless of where the nurse is employed, opportunities to enhance the lives of patients/residents will exist for nurses and advanced practice nurses in South Dakota.

Implications for Nursing Research

Several areas were identified as needing nursing research including the issue of polypharmacy. In 1999, over half of the residents in a nursing facility received nine (9) or more medications and another 25% of the residents received seven or eight (7-8) different medications. Other areas include incontinence of bladder and/or bowel and determining effective interventions since over one-third of the re-admissions to a nursing facility have incontinence problems. The diagnosis of residents admitted to a nursing facility include diabetes, hypertension, CVA, and Alzheimer's as the frequent diagnoses.⁹ Research and resources are needed to help manage, prevent or treat these diseases in earlier stages to alleviate or reduce the length of stays in nursing facilities. Palliative care is receiving a national focus of attention, but more research is needed to identify ways to assist individuals address end-of-life decisions.

References/Notes

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